DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **13-06**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2013**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a)(10)(C)(i)(III) of the Social Security Act** **Section 1905(w) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/13-09/30/13 $ 2.65 Million** **b. FFY 10/01/13-09/30/14 $ 3.53 Million**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Supp 1 to Att 2.6-A: Pages 8, 9** ****SEE REMARKS BELOW**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Supp 1 to Att 2.6-A: Pages 8, 9**

10. SUBJECT OF AMENDMENT:
Medically Needy Income Levels
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: March 25, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **April 29, 2013**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 01, 2013**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: **Michael Melendez**	22. TITLE: **Associate Regional Administrator** **Division of Medicaid and State Operations**

23. REMARKS:

*****This SPA proposes to increase the Medically Needy Income level effective 1/1/2013.***

FORM HCFA-179 (07-92)